

# 2006

# Medical Plan

# Information

Department of Administration • State Personnel Division • Room 125 • Mitchell Building

PO Box 200127 • Helena MT • 59620-0127

1-800-287-8266 or 444-7462 in Helena

[www.hr.mt.gov/benefits/healthbenefits.asp](http://www.hr.mt.gov/benefits/healthbenefits.asp)

# ANNUAL BENEFIT PLAN SUMMARY

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## MEDICAL PLAN



Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315  
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2200  
www.newwesthealth.com

Peak Health Plan • 1-866-368-7325  
www.healthinonetmt.com

## MEDICAL RATES

Monthly Premiums	Traditional	Blue Choice	Peak	New West
Employee	\$475	\$459	\$431	\$388
Employee & spouse	\$647	\$622	\$593	\$538
Employee & children	\$601	\$578	\$552	\$501
Employee & family	\$675	\$648	\$618	\$561
Joint Care	\$535	\$516	\$493	\$448

## MEDICAL PLAN COSTS

**Annual Deductible\***  
*(Applies to all services, unless otherwise noted or a co-payment is indicated)*

**Coinsurance Percentages (% of allowed charges that the member pays)**  
General  
Preferred Facility Services *(See page 34 & 35 for a list of preferred facilities)*  
Nonpreferred Facility Services *(See page 34 & 35 for a list of non-preferred facilities)*

**Annual Out-of-Pocket Maximums\***  
*(Maximum coinsurance paid in the year; excludes deductibles and copayments)*

## MEDICAL PLAN SERVICES

**Hospital Services**  
*(Inpatient services must be certified. Pre-certification is strongly recommended.)*

Room Charges

Ancillary Services

Surgical Services

Outpatient Services

# BENEFIT YEAR 2006

## MEDICAL LIFETIME MAXIMUMS

Each Plan has a set maximum payable per person, per lifetime on the Plan. The amounts shown below are the amounts that the plan would pay per individual.

**Traditional Plan:** \$1,000,000 lifetime maximum; Additional \$2,000 available annually after the lifetime maximum is met.

**Managed Care Plans:** \$1,000,000 lifetime maximum; Additional \$2,000 available annually after the lifetime maximum is met.

TRADITIONAL PLAN		MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan	
Administered by BCBS		In-Network Benefits	Out-of-Network Benefits
\$550/Member \$1,650/Family		\$400/Member \$800/Family	Separate \$500/Member Separate \$1,000/Family
25% 20% 35%		25%	35%
Average of \$2,500/Member (20% - 35% of \$10,000 in allowable charges) Average of \$5,000/Family (20% - 35% of \$20,000 in allowable charges)		\$2,000/Member \$4,000/Family	Separate \$2,000/Member Separate \$4,000/Family
*You pay deductible and coinsurance on allowable charges only (see Glossary on page 4).			
Coinsurance:		Coinsurance/Copayment:	Coinsurance:
20% - 35%		25%	35%
20% - 25%		25%	35%
20% - 25%		25%	35%
20% - 35%		25%	35%
20% - 35%		25%	35%

# ANNUAL BENEFIT PLAN SUMMARY

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## MEDICAL PLAN COSTS

### Physician Services

Office Visits

Inpatient Physician Services

Lab/Ancillary/Miscellaneous Charges

Allergy Shots

### Emergency Services

Ambulance Services for Medical Emergency

Emergency Room

Hospital Charges

Professional Charges

### Urgent Care Services

Facility/Professional Charges

Lab & Diagnostic Charges

### Maternity Services (See page 19 for free services)

Hospital Charges

Physician Charges

Prenatal Office Visits

### Routine Newborn Care

Inpatient Hospital Charges

### Preventive Services

Adult Exams and Tests

Mammogram, gyno exam and pap, proctoscopic  
and colonoscopic exams, PSA tests, bone density tests

Adult Immunizations (Pneumonia and Flu)

Child Checkups and Immunizations

### Mental Health Services

Inpatient Services

*(Inpatient services must be certified. Pre-certification is strongly recommended.)*  
Max : One inpatient day may be exchanged for two partial hospital days.

Outpatient Services

With EAP counselor referral

With NO EAP counselor referral

# BENEFIT YEAR 2006

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
25% (no deductible for first two non-routine office visits)	\$15/visit (no deductible some lab & diagnostic included)	35%
25%	25%	35%
25%	25%	35%
25% (no deductible)	\$15/visit	35%
25%	\$100 copay	\$100 copay
20%-35%	\$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	\$75/visit for facility charges only
25%	25%	25%
25%	\$25/visit	\$25/visit
25%	25%	35%
20% - 35%	25%	35%
25%	25%	35%
25%	\$50 global copay for routine office visits	35%
20% - 35% (no deductible)	25%	35%
25% (no deductible) Max: 2 bone density tests/lifetime Max: \$500 for colonoscopy, sigmoidoscopy, or proctoscopy	\$15/visit (periodic physicals covered, including PSA, PAP, basic blood panel, and other limited lab work) \$0 co-pay for mammogram 25% for bone density scan, sigmoidoscopy, colonoscopy, proctoscopy	35% (plan pays \$75.00 toward mammograms - no deductible)
Not covered	\$15 with office visit 25% (no deductible) without office visit	35%
25% (no deductible) 0% (no deductible for County Health Department through age 5)	\$15/visit Max: Academy of Pediatrics Definitions (through age 18)	35%
20% - 35% 21 days (No max for severe conditions)	25% 21 days (No max for severe conditions)	35% 21 days (No max for severe conditions)
25% Max: 40 visits (No max for severe conditions)	\$15/visit Max: 30 visits (No max for severe conditions)	35% Max: 30 visits (No max for severe conditions)
50% Max: 20 visits (No max for severe conditions)	\$15/visit Max: 30 visits (No max for severe conditions)	35% Max: 30 visits (No max for severe conditions)

# ANNUAL BENEFIT PLAN SUMMARY

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## MEDICAL PLAN COSTS

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### Chemical Dependency

Inpatient Services\*

*(Inpatient services must be certified. Pre-certification is strongly recommended.)*

Outpatient Services\*

With EAP counselor referral

With NO EAP counselor referral

\*Dollar max for all Chemical Dependency Services: Combined inpatient/outpatient max of \$6,000/year; \$12,000/lifetime; \$2,000/year after max is met.

### Rehabilitative Services

Physical, Occupational, Cardiac, Pulmonary, and Speech Therapy

Inpatient Services

*(Inpatient services must be certified. Pre-certification is strongly recommended.)*

Outpatient Services

### Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

### Extended Care Services *(Physician ordered/prior authorization recommended)*

Home Health Care

Hospice

Skilled Nursing

### Miscellaneous Services

Dietary/Nutritional Counseling

*(When medically necessary and physician ordered)*

Durable Medical Equipment, Appliances, and Orthotics

*(Prior authorization required for amounts over \$1,000)*

PKU Supplies

### Organ Transplants *(Must be certified. Pre-certification is strongly recommended.)*

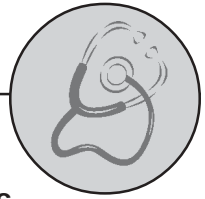
Transplant Services

Lifetime Maximums:

# BENEFIT YEAR 2006

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
20% - 35%	25%	35%
25% Max: 40 visits and Dollar Limit*	\$15/visit Max: Dollar Limit*	35% Max: Dollar Limit*
50% Max: 20 visits and Dollar Limit*	\$15/visit Max: Dollar Limit*	35% Max: Dollar Limit*
20% - 35% Max: 60 days	25% Max: 60 days	35% Max: 60 days
20% - 35% Max: \$2,000/year for all outpatient (\$10,000/year for prior-auth. conditions)	\$15/visit Max: 30 visits	35% Max: 30 visits
25% (plus charges over \$30/visit)	Not covered	Not covered
25% (plus charges over \$30/visit)	Not covered	Not covered
25% (plus charges over \$30/visit) Max: 25 visits in any combination	\$15/visit Max: 20 visits	35% Max: 20 visits
25% Max: 70 days	\$15/visit Max: 30 visits	35% Max: 30 visits
25% (20% - 35% if hospital-based) Max: 6 months	25% Max: 6 months	35% Max: 6 months
25% (20% - 35% if hospital-based) Max: 70 days	25% Max: 30 days	35% Max: 30 days
20% - 35% Max: \$250	\$15/visit	35%
25% Max: \$100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) Max: \$100 for foot orthotics (per foot)	35% Max: \$100 for foot orthotics (per foot)
25%	Plan pays for 100% for services	35%
25%  <ul style="list-style-type: none"> <li>• Liver: \$200,000</li> <li>• Heart: \$120,000</li> <li>• Lung: \$160,000</li> <li>• Heart/Lung: \$160,000</li> <li>• Bone Marrow: \$160,000</li> <li>• Pancreas: \$68,000</li> <li>• Cornea/Kidney: No maximum</li> </ul>	25%  \$500,000 lifetime maximum \$5,000 of the maximum available for travel to and from the facility.	Not covered

# MEDICAL INSURANCE PLANS - 2006



## Administered by:

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315 • [www.bluecrossmontana.com](http://www.bluecrossmontana.com)  
New West Health Plan • 1-800-290-3657 or 457-2200 • [www.newwesthealth.com](http://www.newwesthealth.com)  
Peak Health • 1-866-368-7325 • [www.healthinphonetmt.com](http://www.healthinphonetmt.com)

## WHO IS ELIGIBLE?

Employees, spouses, domestic partners, and children are eligible for the Medical Insurance Plan. Enrollment is only allowed during these circumstances:

- within a new employee's initial 31-day enrollment period;
- within 63 days of becoming a dependent (through marriage, birth, adoption, pre-adoption, or court-ordered custody/legal guardianship);
- within 63 days of losing eligibility (not cancellation) for other group coverage;
- within 63 days of losing an

employee's contribution toward other group coverage, sustaining a major increase in out-of-pocket costs, or losing benefits.

Notify your Agency Insurance Personnel

when one of the above circumstances occurs (within the specified time-frames) to enroll dependents.

## CLICK ON IT!

Learn more about your insurance administrator's customer service by visiting their website at:

[www.bluecrossmontana.com](http://www.bluecrossmontana.com)

[www.newwesthealth.com](http://www.newwesthealth.com)

[www.healthinphonetmt.com](http://www.healthinphonetmt.com)



## INSTRUCTIONS

1. Read about each plan in the General Information section on this page.
2. Review and compare each plan's costs and services in the Benefits Summary, starting on page 6.
3. Review your typical health care needs and look at the Cost Comparisons on page 13.
4. If you are considering a managed care plan, review the Managed Care Areas section on pages 31 through 33, and the provider directories beginning on page 36.
5. Determine which plan will work best for your family. Make your selection by completing Parts 1, 3, 4 & 5 of the Enrollment/Change form.

**Employee Group  
Benefits Enrollment/  
Change Form  
Parts 1, 3, 4 & 5**



## GENERAL INFORMATION

The State of Montana offers an indemnity insurance plan and three managed care plans to choose from:

- Traditional Indemnity Plan
- Blue Choice
- New West Health Plan
- Peak Health Plan

## TRADITIONAL PLAN

The Traditional Indemnity plan is administered by Blue Cross and Blue Shield of Montana (BCBS), which processes claims and payments, provides customer service and notice to members in the form of an Explanation of Benefits (EOB). BCBS also contracts with health care providers to offer plan members a provider network – providers who have agreed to accept certain plan allowances.

## How The Plan Works

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS provider, he or she will submit a claim for the plan member. BCBS will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full

payment. Please verify a provider is currently participating by calling BCBS.

If the provider is not a BCBS provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be unallowed charges which you will have to pay.

## Preferred Facility Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals and surgical centers offer services for members on the Traditional plan that are subject to lower coinsurance rates. Please refer to the Participating Facilities section on page 34 for a list of these facilities. For your protection, it is strongly recommended to pre-certify all inpatient hospital services by calling our plan's customer service phone number, listed at the top of this page.

## Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

## MANAGED CARE PLANS

Blue Choice, New West, and Peak Health are managed care plans offered through the Montana Association of Health Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in costs and requirements for receiving services.

## How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required referral/authorization is obtained).

## In-Network Benefits

When joining a managed care plan, members choose a Primary Care Physician (PCP) who is a member of the plan's network providers. The PCP generally oversees the member's care. A referral/authorization is not required for the plan member to see an in-network specialist. Referrals/authorizations are required to see an out-of-network specialist and still receive the plan's in-network benefits.



## Out-of-Network Benefits

When plan members obtain services from providers who are not part of the plan's network, with no requirement for authorization, costs will be more because a separate and higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

## Out-of-State Services

Plan members may receive in-network benefits for medical services in other states for a medical emergency. For non-emergency services out-of-state, please contact your plan administrator for specific provider network information.

## Major Plan Differences

The major differences in the managed care plans are the services the office visit copayment covers and the process for referrals.

The office visit copayment with the New West plan only includes lab and diagnostic services that are preventive.

For both the Blue Choice and Peak Health plans, the office visit copayment includes any lab and/or diagnostic service that is rendered and billed in conjunction with the office visit.

To obtain a referral or the New West plan, contact New West directly. Referrals for the Blue Choice and Peak Health plans are obtained through your Primary Care Provider.

### IMPORTANT!

BCBS providers for the Traditional plan are different than the BCBS providers for the Blue Choice plan. A provider may be a member provider on one or both plans.

## SERVICE AREAS

The Traditional Plan is available to members living anywhere in Montana or throughout the world. The plan includes services of any covered providers. However, providers who are not

BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.

The managed care plans – Blue Choice, New West Health Plan, and Peak Health Plan – are available to members living in certain areas in Montana. Please see pages 31-33 for a complete listing of covered zip codes for each plan.

## Blue Choice

This plan is available in most of Western Montana and many other towns including Billings, Great Falls, and Havre.

## New West Health Plan

This plan is available in most of Western Montana and many other towns including Billings, Great Falls, Havre, Libby, and Miles City.

## Peak Health Plan

This plan is available to members in Billings, Butte, Deer Lodge, and the surrounding communities.

# MEDICAL INSURANCE COST COMPARISONS

The following medical insurance cost comparisons show how each plan would process the same service, and what costs the plan member would be responsible for paying. The example is cumulative with respect to deductibles and coinsurance. The first line of each example shows the total costs to the member. The next three lines show how that cost is divided between copays, costs applied to the deductible, and coinsurance costs. It does not include premium costs, which are outlined on page 6. These examples assume the services were for one member. This is simply an example for ease of plan comparison and is not a guarantee that similar services will process identically.

EMPLOYEES		TRADITIONAL      MANAGED CARE PLANS			
Sample Services	Allowable Charge		In-Network	Out-of-Network	
Office visits 1, 2, & 3 (\$50 each)	\$150	<b>You pay ➡</b>	\$75	\$45	\$150
Copay costs				\$45 (\$15/each)	
Costs applied to deductible			\$50*		\$150
Coinsurance costs			\$25		
Lab charges with office visit 1	\$75	<b>You pay ➡</b>	\$75	\$75	\$75
Copay costs					
Costs applied to deductible			\$75	\$75**	\$75
Coinsurance costs					
Urgent Care Visit	\$100	<b>You pay ➡</b>	\$100	\$25	\$25
Copay costs				\$25	\$25
Costs applied to deductible			\$100		
Coinsurance costs					
Preferred Hospital inpatient	\$8,500	<b>You pay ➡</b>	\$1,960	\$2,350	\$3,154
Copay costs					
Costs applied to deductible			\$325	\$325	\$275
Coinsurance costs			\$1,635	\$2,025	\$2,879

\*First two office visits are exempt from the deductible.

\*\*May be included in office co-payment